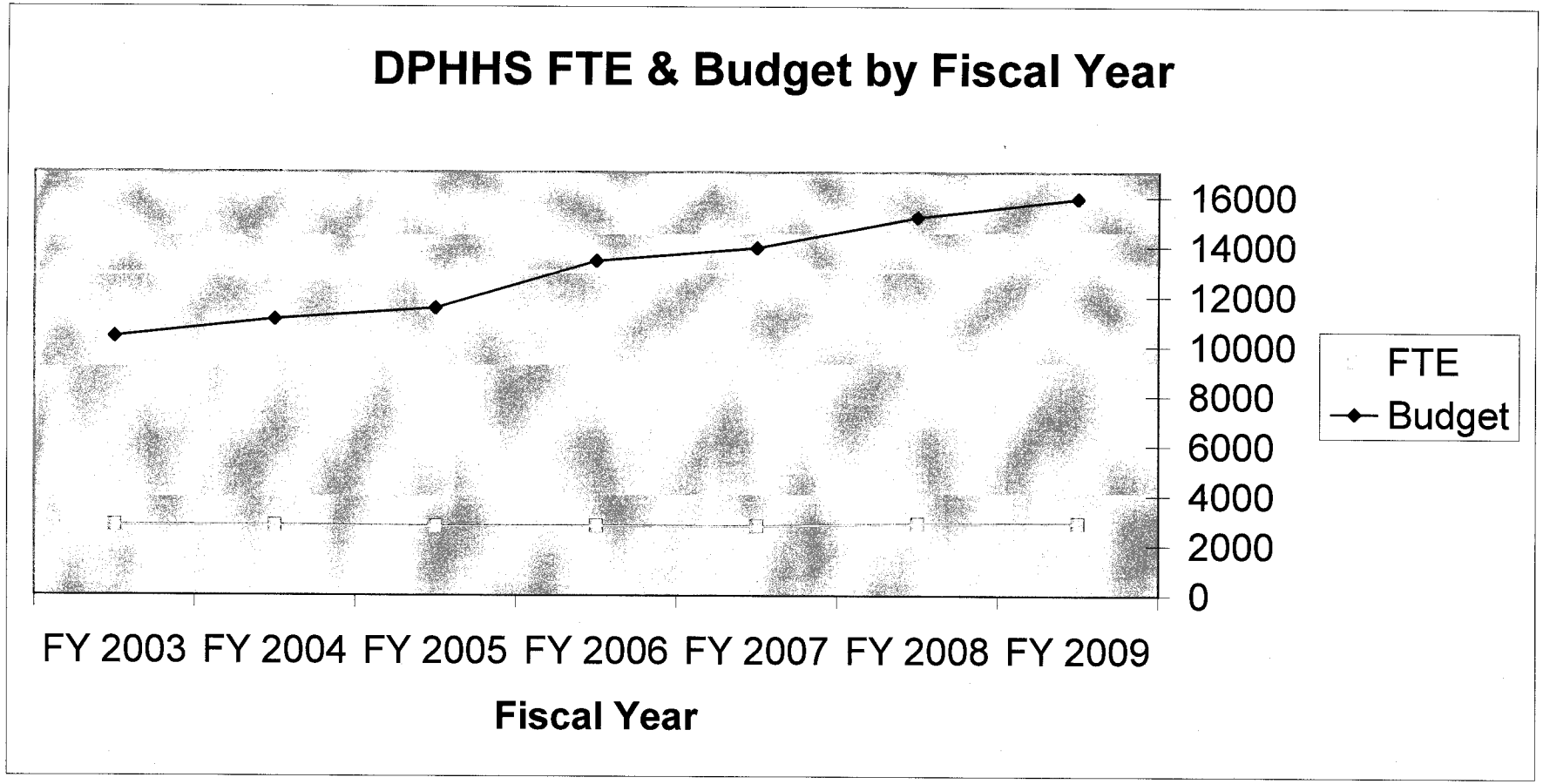
Attachment C



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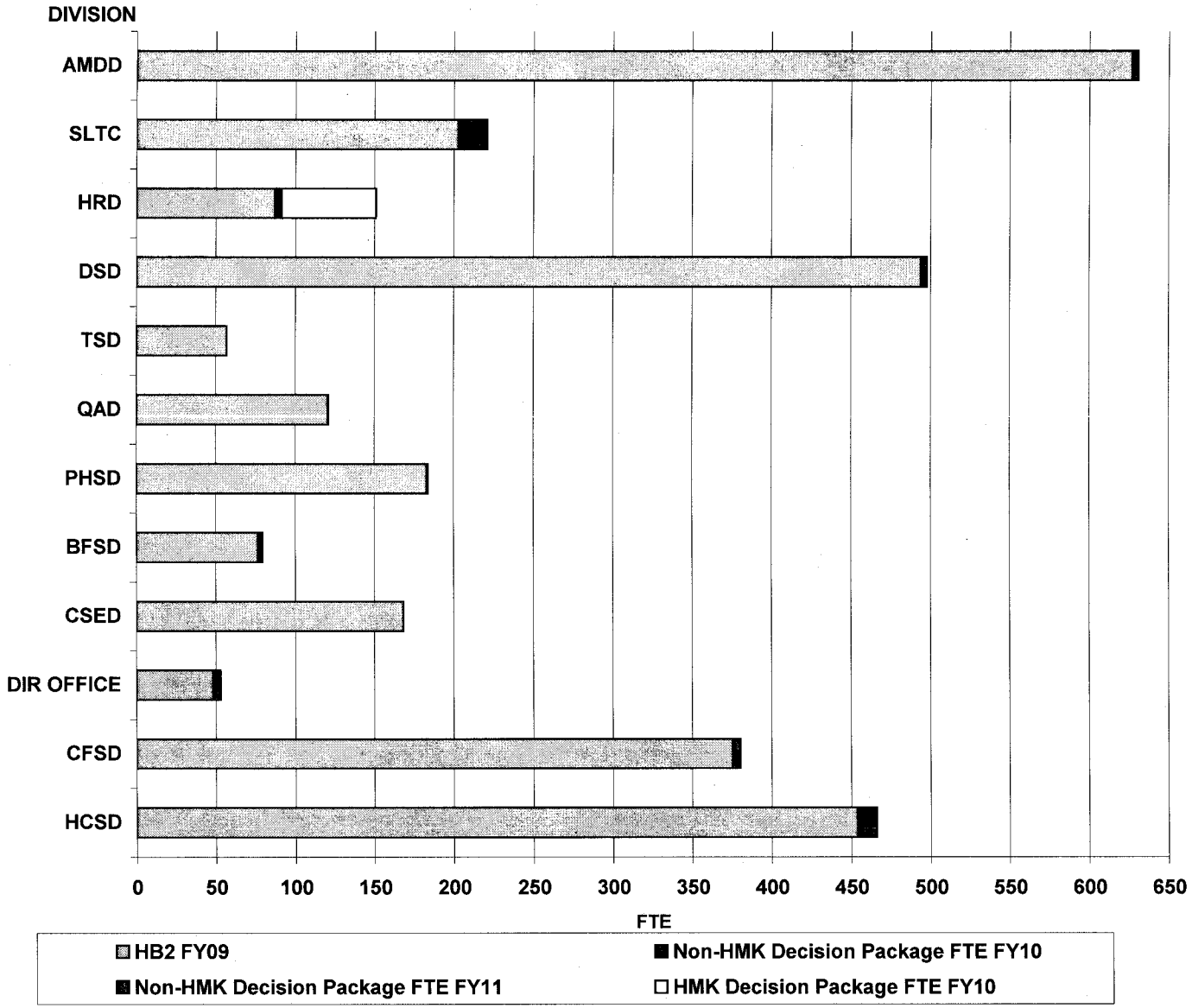
DPHHS Proposed FTE for FY10 FY11



	FY09 (current)	FY10	FY11
AMDD	627.85	631.85 (.64%)	631.85 (.64%)
SLTC	202.74	219.54 (8.29%)	221.04 (9.03%)
HRD	87.00	151 (73.56%)	151 (73.56%)
DSD	496.17	500.17 (.81%)	500.17 (.81%)
TSD	76.10	76.1 (0%)	76.1 (0%)
QAD	120.70	121.45 (.62%)	121.45 (.62%)
PHSD	186.35	187.35 (.54%)	187.35 (.54%)
BFSD	78.50	78.5 (0%)	81.5 (3.82%)
CSED	168.25	168.25 (0%)	168.25 (0%)
DIR OFFICE	55.25	60.25 (9.05%)	60.25 (9.05%)
CFSD	389.45	389.45 (0%)	394.45 (1.28%)
HCSD	455.80	463.3 (1.65%)	468.3 (2.74%)
Total	2,944.16	3047.21(3.5%)	3061.71 (3.99%)
HMK total		60 (2.04%)	0 (2.04%)

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Medicaid Management Information System
Replacement System

Facts about the current MMIS

The Medicaid Management Information System (MMIS) is the Medicaid payment system that processes claims related to enrolled providers and eligible Medicaid, CHIP and Mental Health Services Plan (MHSP) clients. MMIS is a mission critical system that is directly responsible for allowing needy Montana citizens to seek healthcare and healthcare providers to get paid for their services. The current vendor provides maintenance and enhancement services for the MMIS, Pharmacy Benefit Management (PBM), Decision Support System (DSS) and Data Warehouse (DW). The MMIS processes Medicaid, CHIP and Mental Health claims through various payment methodologies housed within the system. Some MMIS statistics:

- In SFY 2008, the MMIS processed over 6.3 million claims reimbursing providers over $650 million for the approximately 120,000 different enrolled clients. There are also over 15,000 enrolled providers in the Medicaid program with the majority located within the State.

Why must we replace MMIS

Montana's current MMIS system is mainframe CICS/VSAM and utilizes COBOL legacy. This technology was first implemented in other states in the late 1970's. The current system has reached end-of-life, which greatly increases the cost and risk of its operation, enhancement, and maintenance. Its technology is more than 30 years old. The current software has several key deficiencies:

- Brittle code (hard-coded, non-modular)
- Outdated programming languages (e.g. COBOL)
- Non-relational database
- Monolithic architecture
- Non-open standards

The impacts of this outdated technology include:

- Difficult to change/add functionality
- Expensive to maintain
- Difficult to find programmers for outdated languages
- Difficult to integrate with other systems
- Difficult to access data without programmer intervention
- Not open to desktop reporting tools

Features of a new MMIS

The RFP for the replacement MMIS includes the MMIS, Pharmacy Benefits Manager (PBM), and the Data Warehouse/Decision Support System (DW/DSS) and is requiring the vendor to implement a state-of-the-art system based on Medicaid Information Technology Architecture (MITA) principles developed by the Centers for Medicare and Medicaid Services (CMS). MITA will greatly increase state's ability to implement business functions in the rapidly changing

health care environment. The State will use MITA as a tool to assist the State in the strategic application of technology and enhancements that provide value and contribute to a continuous improvement in the Medicaid program's maturity.

The new MMIS will (a) greatly enhance functional capabilities, (b) greatly improve the efficiency of its business and service delivery capabilities and (c) provide the framework for an Enterprise Architecture that promotes a standards-based approach to future business agility and capabilities.

In general the new system will possess:

- Modular and reusable component-based design
- Open architecture (not restricted to certain platforms)
- Relational databases (accessible data)
- Graphical Interface (intuitive, easy to use)
- Web-based design
- Business rules engine (separation of policy from code)

Examples of enhanced MMIS functionality that will improve customer service and program efficiency:

- A business rules engine (BRE) that allows the Department to cost effectively create and modify benefit packages for clients under Medicaid, CHIP, MHSP, or other programs that may be created in the future.
- Rules based technology will greatly reduce the effort and cost of implementing changes such as pricing algorithms.
- Provide Direct Data Entry (DDE) claims functionality to allow providers to submit claims online. This will also notify providers more quickly if there is a problem with their claim and allow them to correct and resubmit utilizing the DDE.
- Allow providers to obtain up to date information on eligibility, Medicaid service limitations, cost share amounts and prior authorization information for clients.
- Provide a separate testing region from the production region that supports a test environment for complete end to end testing. This testing would follow a claim from the initial submission through reimbursement to ensure changes are functioning appropriately prior to implementation.
- Provide an impact analysis environment for users to complete 'what if' testing to determine the impact of proposed changes resulting from policy or legislative changes.
- System architecture to facilitate implementation of current national standards such as ICD-10 and new HIPAA transactions.
- Implement new interfaces with other state systems, including death registry, immunization registry and licensure boards.
- Utilize modern Service Oriented Architecture (SOA) design concepts that enable reuse of functionality, sharing of data, and general interoperability between other Department, State, and federal systems.
- Produce provider and client profiling for advanced fraud and abuse detection reports regarding provider billing and client utilization criteria.

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- System architecture to facilitate implementation of current national standards such as ICD-10 and new HIPAA transactions.
- Implement new interfaces with other state systems, including death registry, immunization registry and licensure boards.
- Utilize modern Service Oriented Architecture (SOA) design concepts that enable reuse of functionality, sharing of data, and general interoperability between other Department, State, and federal systems.
- Produce provider and client profiling for advanced fraud and abuse detection reports regarding provider billing and client utilization criteria.

- RFP encourages use of Commercial-Off-The-Shelf (COTS) products which meet the needs of the business function, and encourages use of best-in-class subcontracts when other vendors may offer superior experience and solutions.

Estimated Costs

The Department is requesting $3.5 million in state funding and anticipates being able to leverage additional Department funds to cover the estimated system replacement cost of $65.5 million in total funds. The federal participation for the system development cost is: Medicaid (90%); CHIP (78%); and MHSP (0%).

Risks of Inaction

- The current MMIS base operation cost is $541,632 per month and includes five programmers to complete work for the day to day operations as well as required updates to the system. The base operations cost does not include changes required to the MMIS as set forth by federal or state mandates, such as the National Provider Identifier (NPI) or the Health Insurance Portability and Accountability Act (HIPAA). These projects require approval from CMS for additional monies to complete the mandated updates. The costs for these projects can range from $3.2 to $5.0 million. The Department anticipates that many of the federal and state changes can be made within the functionality of the new system and additional funding will not be needed.
- Due to a proposed federal regulation, ICD-10 is proposed to be implemented by October 1, 2011 to replace the existing ICD-9 diagnosis/procedure codes. ICD-9 currently has about 19,000 codes where ICD-10 may have up to 350,000 codes. This rule is currently in the comment period and we anticipate the final rule will not require state compliance until 2012 or beyond, allowing the change to be made as part of the new MMIS development.
    - Without a current system analysis, the Department is unsure if our existing MMIS can handle the implementation of ICD-10. Depending on timing of the final federal regulation and our replacement timeline, the estimated cost to implement in the current system is $5-8 million (if necessary).
- Failure to accurately and timely process provider payments could result in the MMIS no longer being certified by CMS. In this case, the State would be required to complete a corrective action plan to be reviewed by CMS; they in turn would determine if the MMIS would continue to receive the 50 percent FFP or zero, depending on the circumstances. This loss of certification could also reduce the FMAP rate for Medicaid services from the current 68% to 50% federal match. If this were to occur, the estimated cost would be $150,000,000 in general fund annually.
- In one state, the MMIS failed to accurately and timely reimburse providers for the services provided. In response, many providers turned away Medicaid clients for lack of payment and other providers closed their practices or took out loans to remain open. The impact of providers not accepting clients is unknown as most clients would receive care in hospital emergency rooms which is a higher cost to Medicaid.

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DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Brian Schweitzer
GOVERNOR

Anna Whiting Sorrell
DIRECTOR

STATE OF MONTANA

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To: Health and Human Services Subcommittee
Representative Teresa Henry, Chair

From: Department of Public Health and Human Services

Date: January 23, 2009

Re: Questions from the Subcommittee on vacancy savings and retirement

Question #1 **How many positions are vacant now (January 2009) and what do they do? Why are they open? Which of these positions are held open to meet vacancy savings?**

There are 132.47 vacant fte that are not located in an institution, and 74.25 vacant fte that are located in an institution for a total of 206.72 vacant hb2 fte as of January 15, 2009. Below are tables that indicate the specific number of vacant positions for the institutions, and a table for the non institution positions by division.

Total FTE Vacant not in Institutions	
AMDD	5.50
BFSD	6.00
CFSD	22.20
CSED	5.00
DIRECTORS OFFICE	2.00
DSD	13.50
HCSD	16.75
HRD	19.00
PHSD	22.52
QAD	11.50
SLTC	2.50
TSD	6.00
Grand Total	132.47

Total FTE Vacant at the Institutions	
IN-SH	37.00
IN-MDC	7.63
IN-MVH	1.00
IN-MHNCC	23.62
IN-MCDC	5.00
Grand Total	74.25

For the entire agency, there are currently 22.22 positions that have been identified as being held open to meet vacancy savings requirements.

Summary of Reason	Total
Advertised	38.38
Filled	24.50
Hard to Fill	41.62
Interviewing	28.50
OTO Position	0.50
Under review	34.00
Vacancy Savings	22.22
Will be advertised shortly	17.00
Grand Total	206.72

Question #2 **How many positions would have to be held open to make the 4 percent vacancy savings? (Annual number)**

FY09

NON INSTITUTIONS 1913.57 FTE X 4% = 76.55 FTE

INSTITUTIONS	
STATE HOSPITAL	406.40 FTE X 4% = 16.26 FTE
MDC	267.92 FTE X 4% = 10.72 FTE
VETERAN'S HOME	128.49 FTE X 4% = 5.14 FTE
MH NURSING CARE	122.70 FTE X 4% = 4.91 FTE
MCDC	54.25 FTE X 4% = 2.17 FTE
TOTAL	979.76 FTE X 4% = 39.20 FTE

TOTAL OF ALL FTE 2893.33 FTE X 4% = 115.75 FTE (Based on the assumption that all FTE are funded proportionally)

Question #2 **What groups of positions are most likely to be open and what do they do? See LFD Analysis, page B_____. (Fill in page number where vacancy savings can be found)**

Please refer to division specific reports.

Question #3 **What is the division's total 7 percent vacancy savings and how many positions would have to be held open to make the 7 percent vacancy savings? What additional positions (by group) are most likely to be open and what do they do? List only the additions to the 4 percent list.**

(This is an agency-wide vacancy savings figure - the division calculations are on the division specific reports.)

FY09

NON INSTITUTIONS 1913.57 FTE X 7% = 134.00~ FTE (Based on the assumption that all FTE are funded proportionally)

Additional open positions needed to achieve the 7% vacancy savings will likely be similar or the same types of positions as those listed in response to Question #2 above.

Question #4 **Of the division's anticipated retirements, what positions do the retirees hold? Is the estimated payout still in line with the estimates on page B-6 of the LFD Analysis?**

The table below is an updated version of the eligible retirees. The data being used is from the DOA retiree spreadsheet prepared for all of the agencies. The division details are on their specific reports.

AMDD	338
DSD	295
HCSD	257
CFSD	182
PHSD	94
QAD	78
SLTC	130
HRD	45
DIRECTOR'S OFFICE	26
BFSD	48
CSED	103
TSD	32
Grand Total	1628

The following table shows the actual retirements during 2007 and 2008 by job type and as a percentage of total retirements. This shows that far more employees are actually eligible for retirement than choose to retire. The agency's anticipated Compensated Absence Liability of $1,792,560 (shown in Figure 1, Page B-4, LFD Budget Analysis) is calculated based on the average cost of the likely retirements. The number of likely retirements for the next biennium was predicted based on the actual retirements during 2007 and 2008.

Retirement Distribution by Job Type - FY 2007 & 2008

	Number of Retirements		Percent of Total Retirements	
	2007	2008	2007	2008
Central Employees				
Management	6	6	9.4%	10.3%
Manager/Supervisor (Band 5, 6, 7)	5	6	7.8%	10.3%
Professional/Program (Band 5, 6, 7)	39	27	60.9%	46.6%
Administrative (Band 2, 3, 4)	14	19	21.9%	32.8%
Totals	64	58	100.0%	100.0%
Facility Employees				
Management	0	0	0.0%	0.0%
Manager/Supervisor (Band 5, 6, 7)	1	0	2.9%	0.0%
Professional/Program (Band 5, 6, 7)	9	9	25.7%	24.3%
Administrative (Band 2, 3, 4)	1	3	2.9%	8.1%
Administrative - Medical & Psychiatric (Band 2, 3, 4)	11	10	31.4%	27.0%
Facility Physical Support (Maintenance, custodial, food)	13	15	37.1%	40.5%
Totals	35	37	100.0%	100.0%
Total number of retirements *	99	95		

Central Employees

Management includes positions such as administrators, bureau chiefs, and regional administrators, and a small selection of other top management positions.

Manager/Supervisor (Bands 5, 6, 7) includes positions in manager and supervisor classes such as social service supervisor and computer supervisor,

Professional/Program (Bands 5, 6, 7) includes a broad array of professional positions, social workers, accountants, computer programmers, administrative specialists, nurses and many more.

Administrative (Band 2, 3, 4) includes 'all other' positions not included above such as administrative assistant, eligibility assistant, and clerk.

Facility Employees

Management includes facility administrators, superintendents, and service program managers.

Manager/Supervisor (Bands 5, 6, 7) includes positions in manager and supervisor classes.

Professional/Program (Bands 5, 6, 7) includes a broad array of professional positions, social workers, accountants, computer programmers, administrative specialists, nurses and many more.

Administrative (Band 2, 3, 4) includes 'all other' positions not included above and not included in the Medical & Psychiatric type immediately below.

Administrative - Medical & Psychiatric (Band 2, 3, 4) includes positions such as LPNs, medical record staff and psychiatric aides.

Facility Physical Support (Maintenance, custodial, food service)

Note: Report is based on data from SABHRS HR Personnel Actions History for each of the two fiscal years.

* Previous 2007 retirement count was 98. Record added 8/04/08 created an additional retirement in 2007.

Question #5 **Would the division make cuts in the operating budget to meet vacancy savings? Please identify.**

If needed to achieve the target amount of vacancy savings, divisions can consider reductions in travel, training, equipment purchases and other discretionary operating costs. All operating budget reductions for this purpose will be subject to the review and approval of the agency senior management team in light of overall agency priorities.

All divisions have already submitted a 5% Reduction Plan to the OBPP in preparation for the 2009 session which will be used to guide the initial division fiscal reductions if it becomes necessary.

Question #6 **If the division should have to make cuts to services, which services would be reduced first? Does the division have the authority to eliminate any programs during the interim? Please list the programs.**

Elimination of programs and services is not at the discretion of the division. If program or services reductions are required, the DPHHS senior management team will assess the agency priorities, critical service needs, federal and state mandates, as well as fiscal targets, and make recommendations to the Governor for his consideration.

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MMIS Claims Processing Statistics

1/2006 - 1/2009

Month	Percent processed in 30 days	Percent processed in 90 days	Average Days for Approval
January-09	97.7	99.9	3.8
December-08	96.8	99.7	5.1
November-08	95.1	100	5.3
October-08	95	100	5.8
September-08	91.2	99.9	8.2
August-08	93.9	99.9	6
July-08	94.4	99.9	7.2
June-08	89.8	99.9	8.5
May-08	96	100	5.1
April-08	96.6	99.9	4.9
March-08	96.1	100	4.4
February-08	96.8	100	4.9
January-08	95.3	100	5.7
December-07	96.5	100	4.8
November-07	98.2	100	3.6
October-07	97.8	99.9	4.3
September-07	97.4	100	4.6
August-07	97.3	100	4
July-07	97.8	100	3.9
June-07	97.1	100	3.6
May-07	98.1	100	3.2
April-07	97.2	100	3.6
March-07	96	99.9	4.9
February-07	97.2	100	4
January-07	97.6	100	3.4
December-06	97.3	100	3.3
November-06	98.2	100	2.9
October-06	95.1	100	3.8
September-06	98	100	3.1
August-06	97.4	100	3.3
July-06	97.7	100	3.7
June-06	97.5	100	3.6
May-06	97.6	100	3.5
April-06	85.8	100	6.9
March-06	97.7	100	3.5
February-06	98.4	100	3.3
January-06	98.3	100	4